

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
APR 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11027**

Registration District No. **318**

Primary Registration District No. **2-0-1 54** Registrar's No. **311**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 2, Springfield
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community
years, months or days **1 2 1**

3. (a) PRINT FULL NAME **Isabel Beckner Gibson**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John A. Gibson** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **January 22, 1856**
(Month) (Day) (Year)

8. AGE: Years **84** Months **2** Days **6** If less than one day hr. _____ min. _____

9. Birthplace **Conway** (City, town, or county) **Mo.** (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Lewis Beckner**

13. Birthplace **Ohio** (City, town, or county) (State or foreign country)

14. Maiden name **Sarah** (City, town, or county) (State or foreign country)

15. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **John A. Gibson**

(b) Address **Route 2, Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **3-30-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Captown**

18. (a) Signature of funeral director **George Schaefer**

(b) Address **Springfield, Mo.**

19. (a) **3/30/40** (b) **Chas. A. George**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield (Rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 2**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **28**
year **1940** hour **8** minute **P.** M.

21. I hereby certify that I attended the deceased from **3-28-40** to **3-28-40**
that I last saw him alive on **3-26-40** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure**
Hypostatic pneumonia
Due to **Bronchial**

Due to _____
Other conditions **Senility**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **Daniel L. Yonney, M.D.**
Address **500 HOLLAND BLDG.** Date signed **3-29-40**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

C. Churney....., Registered Apprentice No. 204
working under my personal supervision.

Signed Wayne Hinkle.....

Licensed Embalmer No. 3446

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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